PRINTED: 05/26/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0004	A. BUILDING _____ B. WING _____	05/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATIONAL CHILDREN'S CENTER	1501 GALLATIN ST, NE WASHINGTON, DC 20017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS A licensure survey was conducted on May 21, 2010. A random sampling of three residents was selected from a residential population of four males and two females with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home, as well as a review of the resident and administrative records, including the incident reports.	I 000	Received 6/7/10 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure the interior and exterior of the GHMRP were maintained in a safe, orderly, and attractive manner for six of six residents residing in the facility. (Residents #1, #2, #3, #4, #5, and #6) The findings include: During the inspection of the environment with the GHMRP's program coordinator on 5/21/10, beginning at 4:20 p.m., the following concerns were identified: Interior 1. The carpet on the main floor was observed buckling up which could result in a potential trip hazard. According to the Program Coordinator,	I 090	NCC will have the carpet repaired/"stretched" to remove all buckling removing any/all potential tripping hazards for the residences. Until the repairs are completed, staff will provide personal assistance as needed to the residence by maintaining eye contact and close physical proximity to all individuals when moving about in the main living area.	7/23/10

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I 090	Continued From page 1 the carpet was recently replaced. 2. The bathroom located in Resident #1 and Resident #5's bedroom was inoperable. The door was closed and the door entrance had been taped preventing any entry into the area. According to the Program Coordinator, the bathroom was being renovated and to ensure resident safety, the door had been taped to prevent use. The program coordinator further indicated, that while resident #1 and #5's bathroom was being renovated, they both had access to the main bathroom located on the same floor.	I 090	NCC will completed necessary renovations to resident #1 and #5's bathroom. During the renovations, the bathroom will be secured to prevent physical injury.	7/23/10
I 228	3510.5(e) STAFF TRAINING Each training program shall include, but not be limited to, the following: (e) Resident ' s rights; This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure staff were effectively trained on resident's rights to privacy for six of six residents living in the facility. (Resident #1- #6) The finding includes: Observation of the administration of medication was conducted on May 20, 2010, beginning at approximately 7:00 a.m., the trained medication employee (TME) and a direct care staff was present during the administration of the resident's medications. Each resident was sitting in the den area as foot treatments, eye treatments and medications were being administered. No client	I 228	NCC will suspend the TME in question from the administration of medication until such time completion of retraining on "Rights of Privacy" with focus on administration of medication is completed and successfully passed. NCC RN will conduct observation of the TME administering to ensure comprehension of the values expressed in the formal training.	7/23/10

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I 228	Continued From page 2 was provided with privacy. Interview with the facility's supervising Register Nurse (RN) and Quality Improvement Director on May 20, 2010, at approximately 9:20 a.m. and the Program Coordinator respectively at 4:00 p.m. later that day, revealed that the facility had trained all TME's May 19, 2010, on ensuring client rights and privacy during the medication administration. The GHMRP failed to ensure all staff received effective training in the area of Resident's Rights as required by this section.	I 228		
I 391	3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (a) Medicine; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide medical services to ensure the health and safety needs of Resident's #1 and #3. The findings include:	I 391		

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I 391	Continued From page 3 1. The facility's medical team failed to follow-up on a recommendation for a medication change and abdominal ultrasound for Resident #1's, as follows: a. On 5/21/2010, at approximately 3:20 p.m. a review of resident #1 medical record revealed a GI consult dated 1/30/08,. According to the consult, resident #1 was seen for a follow up colonoscopy for Crohn disease diagnoses. At that time, the GI specialist prescribed Miralax powder 1 dose, by mouth every PM as needed, for constipation. Review of the physician orders sheets on May 21, 2010 at 2:20 p.m., however failed to evidence that the prescribed medication had been ordered. Interview conducted with the Program Coordinator on 5/21/2010 at 3:30 p.m., revealed he was unaware of the order for Miralax powder. He further indicated that the Register nurse (RN) would be informed for immediate action. b. On 6/30/09, Resident #1 was sent to the Emergency room (ER) for abdominal pain. Review of the ER discharge summary revealed the resident was diagnosed with "cholelithiasis-non OBS." On 1/21/2010, resident #1 was seen by the GI specialist for gallstone assessment, recommending that a follow-up abdominal ultrasound be ordered, to assess status of gallstones. Interview conducted with the Program coordinator at 3:30 p.m. on the same day, revealed to his knowledge the recommended ultrasound had not been completed. 2 The facility's medical team failed to follow-up on Resident #3's 1/20/2010, dental	I 391	NCC obtained PCP order for Miralax on 6/3/2010 as stated in the March 2010 physician's notes. The order is an over-the-counter medication for complaints of occasional constipation. The Program Coordinator and nurse will meet on a regular basis to review all medical consults and physician's notes/orders to ensure that all physician's orders are acted upon in a timely manner. Resident #1 will have a follow up abdominal ultrasound completed to assess the status of gallstones on June 8, 2010.	6/7/10 6/8/2010

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I 391	Continued From page 4 recommendation for a maxillary palate biopsy as follows: On 5/21/2010, at approximately 3:35 p.m., a review of resident #3's 6/3/09, dental consult was completed. The consult findings revealed a medium size erythematous patch on his anterior palate, which may need a biopsy. On 1/20/2010, resident #3 returned to the dentist as recommended for a follow up assessment. The dentist recommended that a biopsy of anterior maxillary palate was needed and would require a signed consent. Interview conducted with the Program Coordinator on the same day and time, revealed the recommended palate biopsy had not been performed due to no consent. Reportedly, resident #3's guardian had passed away. Further interview and record review revealed documentation completed by the program coordinator to resident #3's service coordinator requesting assistance in obtaining a guardian and consent. However to date, (5 months later), the GHMRP had not heard back on the status of their request for a guardian, nor had consent been obtained.	I 391	An Emergency Case Conference will be scheduled with DDS Service Coordinator and DDS Supervisor of Service Coordination to obtain medical consent. Upon receipt of medical consent, biopsy appointment will be scheduled.	7/23/10
I 470	3522.1 MEDICATIONS Drugs shall be administered as set forth in the User Of Trained Employees to Administer Medications to Persons of Mental Retardation or Other Developmental Disabilities Act of 1994, D.C. Code, sec. 21-1201 et seq. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP Trained Medication Employee failed to implement the agency policies and procedures for administering each Resident's medication regimen.	I 470		

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I 470	Continued From page 5 The findings includes: Observation of the medication pass on May 21, 2010, at approximately 7:00 a.m. revealed that the staff administering medications to all six residents, was a Trained Medication Employee(TME). Review of the agencies policy and procedure manual revealed that the governing body had adopted the Title 17 DCMR, Chapter 61 Trained Medication Employee regulations into its policy and procedures. These regulations required proof of satisfactory completion of the TME course and a copy of the certification is to be on file at the facility in which the TME is employed. Record review of the Trained Medication Employee's personnel record on May 21, 2010 at 9:30 a.m., did not evidence a current certificate. The record evidence that the TME's certificate (TME 318) expired October 31, 2009. Interview with the agencies Register Nurse at 9:35 a.m. on May 21, 2010, revealed the re-application process had been an over site, however required application for the certificate had been submitted and proof was provided for review. Further interview with the facilities program coordinator at 4:00 p.m., revealed the TME would not be allowed to administer resident medications until her certificate had been obtained. At the time of the survey, the GHMRP failed to ensure that all TME certifications were maintained to ensure the health and safety of all residents residing in the facility.	I 470	NCC will not allow TME to administer resident's medications until her certification issue has been resolved with the Board of Licensing. (NOTE: Documentation submitted 4/10 to the Board of Licensing for re-certification; please see attached documentation.)	7/23/10

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I 470	Continued From page 6 This issue was referred by this office to the District of Columbia Board of Nursing and Medical Board for further evaluation.	I 470		